Children's Community Health Plan

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Toll-free: 1-800-482-8010
www.childrenscommunityhealthplan.org

# Practitioner/Provider Change Notification Form

Please complete this form to report changes regarding an individual practitioner and email it to cchp-credentialing@chw.org

***Required fields in bold.**

| | | |
|---|---|---|
| Requestor's Name:<br>Title: | | Phone:<br>Email: |
| Changes for (Name of Person or Clinic/Group): | | |
| Current Practice Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| **Practitioner** change type (check all that apply):<br>☐ Name ☐ Licensure ☐ Term Status<br>☐ Term Location ☐ New Location ☐ Add Location | **Provider** change type (check all that apply):<br>☐ Name ☐ New Location ☐ Term Location<br>☐ Add Location ☐ Other _____ | |
| **Effective Date (MM/DD/YY):** | **NPI:** | **TIN:** |
| Licensure: | Specialty: | |
| *Name Change* | | |
| Previous Name: | | |
| Current/Updated Name: | | |
| *Term Location* | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| *New Location* | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| *Additional Location* | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Comments: | | |

Please submit any questions to the email addresses listed above. Thank you.

**Covering you. Covering your kids.**